Wounded Spirits, Ailing Hearts

PTSD and the Legacy of War Among
American Indian & Alaska Native American Veterans

3. Care: VA and Indian Health Service Health Care Services

Native Veterans tend to seek medical care from the two largest health care systems available to them: VA medical centers and outpatient clinics, and Indian Health Service (IHS) hospitals and clinics. Analysis of veteran use and satisfaction with VA and IHS services found the following:

More than half of the American Indian and Alaska Native Vietnam Veterans who went to VA or IHS facilities rated the medical care "good or excellent."

Unfortunately more than half were not currently receiving any medical care, despite often having chronic physical health problems.

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Barriers to VA/IHS Care

Numerous barriers have kept American Indian and Alaska Native Veterans from seeking the VA or IHS medical care to which they are entitled. Sometimes hospitals and clinics have been too far away to reach. Sometimes Veterans have lacked trust in the VA and IHS or have considered the quality of care to be poor. Both the VA and IHS health care systems are working to make medical care more accessible, more dependable, and of high quality. Professional staff and patient advocates are aware that every patient is entitled to respectful, quality care.

Other barriers to seeking quality medical care from the VA or the Indian Health Service are the following concerns about needing or benefiting from medical care, which are endorsed by many Veterans and/or their families:

- Want to solve problem on my own
- Believe problem not serious enough
- Believe treatment won't help
- Worry about what others would think

PTSD contributes to negative attitudes toward health care. The desire to avoid trauma reminders may lead the veteran to avoid necessary health care. Hyper-vigilance and anger may lead to excessive distrust of and hostility toward healthcare providers. Social isolation and emotional numbing can prevent asking for help.

"I just didn't understand. I just had no patience. I would get angry. And all these things that I'm supposed to be getting treatment for are those things that are preventing me from getting that, because I didn't want to deal with the system."

PTSD and **Mental** Health Care

Three quarters of American Indian and Alaska Native Vietnam Veterans have significant mental health problems (including PTSD, alcohol and substance abuse, depression, and panic disorder). The great majority have not received any mental health services. In the MVVP more than 5 in 6 (84%) had not received any mental health care in the past year.

Barriers to participation in mental health care noted in the MVVP included most of those that also prevented use of medical care:

- Hospital/clinic too far away
- Needed care not offered
- Too much red tape at the VA/IHS
- Quality of care poor at the VA/IHS

- Not eligible for VA health care services
- Encountered/feared racial prejudice

But many people reported additional fears and concerns about seeking mental health treatment.

"I was kind of afraid they would just confine me in some facility...they suggested the PTSD treatment center in California. And they said it [treatment] took three months. And I said to myself, you know three months, boy, that's a long time. I wondered is it like a dormitory or a barracks? I kind of pictured a barracks, with bunks lined up on each side of the wall and kind of run like the military...So I said, Oh, I wouldn't like it. But they assured me that it was a good setting. And when I came here to the VA Medical Center it wasn't like [my] picture. So when I got here. I knew I would get help."

Sometimes, Veterans have had bad experiences with VA mental health services in the past. Some are now finding that services have changed for the better.

"I had an incident where I had went into the VA looking for information for a problem, and the person was trying to get me to see a doctor And I said, 'What don't you understand about what I'm asking you?' And they told me, 'Well, where do you come off having an attitude?' And so, it wasn't necessarily that they didn't want to help me. It's that we didn't understand each other.

...[But] now, when you go to the VA...they have an awareness and an understanding of it... They don't always have an answer; but they always have an open hand. They always have a fresh cup of coffee. And they always have an open area. And they'll let you sit there and talk. They'll support you. They'll do the best they can to explain what they heard from you. And if they can't, they'll find someone in that office that will."

VA PTSD Programs and Vet Centers

The VA has set up specialized PTSD treatment programs as well as community clinics (Readjustment Counseling Service "Vet Centers") in more than 200 locations across the United States. Providing Vet Centers is one way VA is making better care more available. Several Vet Centers are located within reservation tribal communities, so Veterans don't have to travel hundreds of miles for counseling and other services. Vet Center staff often seek out Veterans in schools, homeless shelters, addiction rehabilitation programs and support groups, and prisons - where many Veterans struggling with PTSD can be found. Vet Centers are often staffed by counselors who themselves are American Indian or Alaska Native Veterans.

Traditional Healing

American Indian and Alaska Native communities enjoy a rich history of traditional forms of healing. For hundreds of years, tribal healers have provided a range of herbal and ritual treatments for physical and spiritual problems. Tribal leaders and elders serve as spiritual guides and conduct elaborate healing ceremonies that include the entire community in ritual activities such as dance, chanting, meals, fasts, physical challenges, or sweats. In traditional healing encounters, prayer and ceremony tap the strength housed within family, community, and Creator. Recently more American Indian and Alaska Native Veterans are drawing on these resources for help with both physical and mental health problems. Traditional healing options can go hand in hand with conventional western medicine and counseling.

"I needed to take a stand, take a step forward, be able to, be open for these things to have any good things for me. And so, basically, that's what I did. It was one little step at a time. I started doing sweat lodges over the years.... On the behalf of Veterans, we sponsored Native American church meetings for healing. Over the course of the whole thing, I've participated in numerous ceremonies that each have a little cog in it, a little step.... All these things helped me."

Roles of Health Care Providers

Healthcare providers often are the first and only contacts that Native Veterans are willing to make for help in healing. Seeking medical care for a physical illness often is more socially and personally acceptable for Native Veterans (and their families) than seeking psychological treatment for "mental illness" or addiction. During the routine health and medical history, health care professionals must be alert to the symptoms of PTSD, as well as to a variety of problems that are sometimes associated with PTSD and that warrant further inquiry:

- Anger or hostility
- Social isolation
- Grossly disturbed interpersonal relationships (e.g., violence in intimate relationships, inappropriate sexual behaviors)
- A wide variety of somatic complaints
- Smoking
- Poor nutrition
- Poor self-care

Patients vary greatly in degree of impairment. For example, some individuals may exhibit high levels of interpersonal, social, and vocational functioning, whereas others may be totally incapacitated and may appear to have a mental illness such as chronic schizophrenia.

If trauma or PTSD is suspected, a sensitive and careful exploration is extremely important. Obtaining a trauma history is an essential first step in diagnosing PTSD and distinguishing it from other major mental disorders. Although patients most often welcome the opportunity to talk about their trauma, it can often be stressful for them. At first, the discussion will likely be quite brief; and at that point, the patient can be referred to a psychiatrist or psychologist for further evaluation. Initially American Indian and Alaska Native Veterans, like most people, may be more open to meeting with a "stress management" clinician - one who is also a specialist in PTSD, depression, and alcohol or drug abuse - than to be referred to a mental health practitioner.

A four-question, symptom-related paper-and-pencil screening instrument can be used in primary care and other medical settings (Prins and Kimerling, 2004). This PTSD screening instrument has shown promising psychometric properties for detecting those individuals with more severe trauma-related difficulties. A positive response to the screen does not necessarily indicate a problem with posttraumatic stress. However, it indicates the need for sensitive questioning by a helping professional. We recommend that these questions be embedded in a more comprehensive screen used to assess health behaviors, mental health problems, and perceived health difficulties. Further questioning about trauma and its effects would be warranted if a patient responded "YES" to two or more of the following items (all use yes or no response format):

Have you ever had an experience that was so frightening, horrible, or upsetting that, in the past month you...

- Have had nightmares about it or went out of your way to avoid situations that reminded you of it?
- Tried hard not the think about it or went out of your way to avoid situations that reminded you of it?
- Were constantly on guard, watchful, or easily startled?
- Felt numb or detatched from others, activities, or your surroundings?

In discussing traumatic stress symptoms, it is important to inform patients that traumatic events and the distress they create can have important effects on the body and on health as well as on the patient's psychological functioning. The health care provider can explain that he or she is opening this discussion as part of an effort to provide more comprehensive health care. The patient should be made aware that greater understanding and recognition of symptoms of posttraumatic stress and, if appropriate, help from a professional will be of benefit, both physically and psychologically.

The Primary Care Provider's Role

Primary care practitioners play key roles in case identification, patient support, referral, treatment of associated medical problems, delivery of pharmacotherapy and overall patient management. In general, primary care providers should be expected neither to initiate pharmacological treatment nor to assume full responsibility for its management. The patient with PTSD will likely require, at minimum, a medication consult and on-going management by a psychiatrist experienced in PTSD treatment.

There is no question that medications and behavioral interventions can provide some symptomatic relief of anxiety, depression, insomnia, and other symptoms of PTSD. Timely, brief psychological assistance can prevent or greatly reduce the onset or severity of PTSD and decrease the overall cost of medical care. A working model of patient management might include the following steps:

First

Identify a mental health or PTSD specialist (e.g., psychologist, social worker, psychiatric nurse, psychiatrist, community clinic, rape crisis center) that can act as a source of professional consultation, patient assessment, patient education, and psychological or psychiatric treatment.

Second

Administer a brief self-report or interview screen to all patients or to patients whose combat history or current signs or symptoms suggest the possible presence of PTSD (see PC-PTSD, or screening for PTSD on this website).

Third

For those patients who screen likely for PTSD, establish a plan for referral to the identified specialist or clinic. The medical provider should then ensure that the patient complies with this crucial part of his or her treatment plan.

Finally

An equally critical step is to maintain on-going contact with the mental health or PTSD specialist in order to monitor the patient's compliance and responses to mental health intervention.

Trauma Exposure/PTSD Screening

Inquiry regarding exposure to trauma and possible symptoms of PTSD can be part of a routine intake protocol. The use of screening interview questions or written questionnaires provides the practitioner with an efficient and comfortable way of introducing the topic of trauma.

If the patient has been given the written screen, the practitioner can say:

"I notice from your answers to our questionnaire that you experience some symptoms of stress. Many people have experienced extremely distressing events at some time in their lives, especially during war, and sometimes those events lead to the kinds of symptoms you have. Have you ever had an experience like that?"

If the screen has not been administered, the following sentence may help to introduce the subject:

"Many Veterans experienced extremely distressing events, such as firefights, during their military service. Did you have any experiences like that?"

For those patients who screen likely for PTSD, a previously identified referral plan, such as to a PTSD specialist or clinic, should be implemented. As previously mentioned, the medical provider should then ensure that the patient complies with this crucial part of his or her treatment plan. In order to monitor the patient's compliance and progress, the medical provider should maintain on-going contact with the mental health or PTSD specialist.

The Psychiatrist's Role

The psychiatrist can play important roles in evaluation, case management, and pharmacotherapy. In addition, the psychiatrist can provide the patient with appropriate additional referrals. The psychiatrist's prescription and management of the patient's medications is often pivotal to overall improvement. A main function of medications is to provide a degree of relief in order to facilitate patients' participation in psychotherapy. In most cases, combined pharmacological and psychotherapeutic treatment for PTSD is more effective than either conducted alone. The following topics are described below:

- Associated Psychophysiological Changes
- Medications
- Comorbidities and Medication Selection

Associated Psychophysiological Changes

Research indicates that PTSD may be associated with stable and enduring neurobiological alterations of both the central and autonomic nervous systems. Neuropharmacologic and neuroendocrine abnormalities have been detected in the noradrenergic, hypothalamic-pituitary-adrenocortical, and endogenous opioid systems - all of which have direct effects on physiology, mental health, and adaptive functioning.

More specifically psychophysiological alterations associated with PTSD include hyperarousal of the sympathetic nervous system, increased sensitivity and augmentation of the acoustic-startle-eyeblink reflex, a reduced pattern of auditory

evoked cortical potentials, and sleep abnormalities. PTSD results in vulnerabilities to abnormalities of thyroid functioning and other hormone fluctuations, and increased susceptibility to infections and immunologic disorders. Other associated difficulties include problems with pain perception, pain tolerance, chronic pain, and gastrointestinal disturbance.

Medications

Unfortunately, there is a paucity of published literature on pharmacotherapy for PTSD. Further, the complexity of PTSD makes it difficult to predict which classes of drugs might be expected to improve which clusters of symptoms.

In most, but not all, trials, improvement has been achieved with tricyclic antidepressants such as imipramine, amitriptyline, or possibly nortriptyline or desipramine. Desipramine and nortriptyline generally have less anticholinergic, sedative, or orthostatic hypotension effects and may be useful for the elderly patient. Additionally the monoamine oxidase inhibitors (MAOIs; e.g., phenelzine), the selective serotonin reuptake inhibitors (SSRIs; e.g., fluoxetine), and propanolol have offered improvement.

Choice of medication may be tailored to specific focal symptoms. For example, intrusive and avoidant symptoms may be improved with tricyclics, MAOIs, SSRIs, and possibly valproate. However, these may prove to be more recalcitrant to psychopharmacological treatment than other symptoms. The SSRIs (e.g., fluoxetine, paroxetine, sertraline) are effective for symptoms such as rage, aggression, impulsivity, and suicidal behaviors. However, because of medication side effects such as arousal or insomnia, the SSRIs may be intolerable for some patients.

In general, pharmacological treatment may begin with an SSRI. However, should this prove to be too stimulating, a 5HT2 antagonist (e.g., nefazadone) may be warranted. General dose ranges for the SSRIs are: fluoxetine (20-60mg); sertraline (50-200mg); paroxetine (10-50mg). Titrating the dose upward too fast or stopping too soon are often the reasons for the apparent ineffectiveness of the SSRIs.

Therefore, the SSRI should be increased gradually toward the higher dosage spectrum and should continue at this level for three months. At this point, the patient should be reevaluated for residual PTSD symptoms. To address symptoms not otherwise controlled by SSRIs, other medications may then be added to the regimen. To assist the patient and inform any other health care provider, give the patient a wallet card stating your prescribed medications.

Comorbidities and Medication Selection

Adding further complication to the choice of medications is the likely presence of one or more comorbid medical and psychiatric disorders. For example, a careful

screening must be made for the presence of a Bipolar disorder. In this case, because of their arousal features, SSRIs as first line medications are contraindicated. Treatment may begin with valproic acid, carbamazepine, gabapentin, venlafaxine, or bupropion. Once the patient is stabilized SSRIs may then be cautiously added to the drug regimen.

When selecting medications, the clinician must try to prescribe a drug that might be expected to improve PTSD symptoms and the comorbid disorder(s) concurrently. Unfortunately little is known about the influence of comorbid disorders on choice of medications because most drug trials have not attempted to balance the various experimental groups with respect to comorbidities. However, taken as a whole, the most common comorbid disorders (depression, panic disorder, obsessive-compulsive disorder, and chemical abuse or dependency) respond to SSRI treatment.

The complex symptoms of PTSD require careful monitoring and management. For example, the SSRIs (as with many other antidepressant agents) can potentially interact with many other drugs metabolized by the liver. In addition, the effectiveness of any antidepressant may be affected by other drug therapy. Further, drug-drug interactions may pose risks. Therefore, as with any medication, it is necessary to review medication profiles prior to prescribing any agent.

As always, physicians should be alert to the likelihood of dropout from medical care as a result of medication side effects and should, therefore, take prophylactic steps to increase compliance with treatments. A watchful eye can aid in preventing compliance problems, recidivism, dropout, and complications. In particular, adequate dosing and length of trial is necessary. Many American Indian and Alaska Native Veterans who suffer from PTSD also drink heavily and providers should be especially cautious of interactions between alcohol and medications.

The Mental Health Provider's Role: Therapies

Mental health professionals have a variety of assessment tools available to them to appropriately diagnose PTSD. The Clinician Administered PTSD Scale (CAPS) is a structured clinical interview designed to assess adults for the seventeen symptoms of PTSD outlined in DSM-IV along with five associated features (guilt, dissociation, derealization, depersonalization, and reduction in awareness of surroundings). The CAPS has standardized prompts and follow-up questions, and a behaviorally-anchored 5-point rating scale corresponding to the frequency and intensity of each symptom listed.

Mental health professionals can offer expert education, counseling, and psychotherapeutic interventions that have been empirically shown to help recovery from PTSD. Many psychotherapeutic approaches have recognized merit in the treatment of PTSD. A survey of experts in the field of PTSD recognized cognitive

therapy, exposure therapy, anxiety management training, and psychoeducation as the psychotherapeutic treatments of choice for adults.

"He came back [from the VA treatment program] and he said, Oh, I feel so good, you know... he talked about how the counselors helped him into getting a lot of this out and talking about all this stuff that was ugly to him, and he never even talked about it to anybody. And there was even a time that he said he missed 'em and that he wished that they could be there."

Below several types of therapy are described:

- Cognitive-behavioral therapy (CBT): Includes cognitive therapy and types of exposure therapy
- Anxiety management training (AMT)
- Psychoeducation

Cognitive-behavioral therapy (CBT)

Among psychotherapies, CBT treatments have received the most empirical study. CBT methods, together with psychoeducation, are the most recommended psychotherapy techniques. CBT includes methods such as:

- Cognitive therapy—modification of unrealistic assumptions, beliefs, and automatic thoughts that lead to disturbing emotions and impaired functioning.
- Imaginal exposure—the repeated verbal recounting of the traumatic memories until they no longer evoke high levels of distress.
- In vivo exposure—confrontation with situations that are now safe, but which the person avoids because they have become associated with the trauma and trigger strong fear. Repeated exposures facilitate habituation to the feared situation.

Anxiety management training (AMT)

AMT techniques may also be classified as CBT techniques. AMT teaches a set of tools to deal with stress and anxiety.

- Relaxation training—management of fear and anxiety through the systematic relaxation of the major muscle groups or the imagining of relaxing images.
- Breathing retraining—the use of slow abdominal breathing to help the patient relax and/or avoid hyperventilation with its unpleasant and often frightening physical symptoms.
- Assertiveness training—teaches expression of one's wishes, opinions, and emotions appropriately and without alienating others.

Psychoeducation

Psychoeducation provides patients (and often families) with information about the symptoms of and the various treatments for PTSD.

Psychotherapy conceptualized and implemented with sensitivity to the cultural context of American Indian and Alaska Native Veterans can provide a powerful healing experience for the patient and a learning experience for the practitioner.

Toward Culturally Competent Care

The construct of PTSD has been criticized from the perspective of cross-cultural psychology and medical anthropology because it has usually been diagnosed by clinicians from Western industrialized nations working with patients from a similar background. Major gaps exist in our understanding of the effects of ethnicity and culture on the phenomenology of posttraumatic syndromes. Only recently have vigorous ethnocultural strategies been employed to delineate possible differences in cross-cultural impacts of traumatic exposure and its intrapsychic effects and clinical manifestations.

It is important that both psychological and pharmacological interventions be adapted carefully to the cultural and spiritual expectations and realities of American Indian and Alaska Native Veterans. The DSM-IV provides an outline for the cultural formulation of a patient's signs and symptoms within the patient's cultural context:

- Ascertain the cultural identity of the individual.
- Consider the extent of involvement in both the culture of origin and the majority culture. Also note language abilities, use, and preference(s).
- Identify and explain the symptoms within the cultural context.
- Identify the predominant idioms of distress through which symptoms or the need for social support are communicated (e.g. "nerves," possessing spirits, somatic complaints, inexplicable misfortune).
- Identify the meaning and perceived severity of the individual's symptoms in relation to the norms of the cultural reference group.
- Identify any local illness category used by the individual's family and community to identify the condition.
- Identify the perceived causes or explanatory models that the individual and the reference group use to explain the illness.
- Identify current preferences for and past experiences with mainstream, alternative, and traditional sources of care.
- Identify social supports and stressors.

Cultural factors related to the psychosocial environment and levels of functioning include culturally relevant interpretations of social stressors, available social

supports, and levels of functioning and disability. This would include kinship ties and the role of religion/spirituality in the patient's life.

Facilitate awareness of cultural differences between the individual and the clinician. Consider such factors as:

- Difficulty in communicating in the individual's first language.
- Difficulty in eliciting symptoms and understanding their cultural significance.
- Difficulty in negotiating an appropriate relationship or an appropriate level of intimacy.
- Difficulty in determining whether a behavior is normative or pathological.

Some practical factors to keep in mind

Conceptualize PTSD as a wounding of the spirit. A disturbance has occurred in the connectedness, reciprocity, balance, and coherence of the veteran's world. Start with a full measure of patience and aim for basic human understanding.

Let the veteran know you are interested in his or her well being.

Listen with empathy.

Respect silences; allow long latencies in responses. Do not interrupt the speaker. This may be interpreted as "you're not really listening."

Selectively validate feelings.

Do not expect prolonged "eye contact", as the veteran will likely feel more comfortable looking away from you, rather that at you.

Family and clan are very important. Options may need to be discussed with the group prior to a decision being made. Elders are honored.

American Indian and Alaska Native Veterans' culture is based on the sharing of resources.

"Hallucinations" are an important part of the American Indian and Alaska Native spirituality. In American Indian culture, people may "see spirits."

Try to obtain the nature of what the spirit did or said. If the message was bad or evil, then consider pathology.

American Indian and Alaska Native Veterans' cultures share a present orientation; therefore memories of trauma often are not "put in the past" and thus may be "brought up" quickly and with as great an intensity as when they happened.

Traditional Native American values that may clash with dominate society values

Dominant Society Values	Native-American Traditional Values
Self is the priority (Take care of #1)	Tribe and extended family first, before self
Prepare for tomorrow	Today (is a good day)
Time (linear; use every minute)	Time - a right time/a right place/non-linear
Youth (value rich, young, beautiful)	Age (knowledge, wisdom)
Compete to "get ahead"	Cooperate
Be aggressive	Be patient
Speak up	Listen (and you'll learn)
Take and save	Give and share
Conquer nature	Live in harmony (with all things)
Skepticism and logical thinking are valued	Great mystery - the intuitive honored
Self is more important than group	Humility
Religion is a part of life	A spiritual life (religion not "separate")
Be a critical thinker	Don't criticize your people
Live with your mind	Live with your hands - manual activity is sacred
Orient yourself to a house and job	Orient yourself to the land
You're in America: speak English!	Cherish your own language and speak it when possible
Discipline your own children	Children are a gift of the Great Spirit to be shared with others
Have a rule for every contingency	Few rules are best, loosely written and flexible
Have instruments judge for you	Judge things for yourself